

Doctor-patient relationships in general practice—a different model

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Author's abstract

Philosophical concerns cannot be excluded from even a cursory examination of the physician-patient relationship. Two possible alternatives for determining what this relationship entails are the teleological (outcome) approach vs the deontological (process) one. Traditionally, this relationship has been structured around the 'clinical model' which views the physician-patient relationship in teleological terms. Data on the actual content of general medical practice indicate the advisability of reassessing this relationship, and suggest that the 'clinical model' may be too limiting, and that a more appropriate basis for the physician-patient relationship is one described in this paper as the 'relational model'.

Traditionally, the patient-physician relationship has been structured around the concept of what can be called the 'clinical model' which is utilitarian and teleological in its interpretation of the relationship. The patient is seen as having a disease produced by either an external factor or a malfunctioning structure which is the source of pain and unhappiness. The recognition and treatment of this disease, *ie* effective management, is the goal of the physician which, if successful will restore the patient's well being. As such, the relationship between physician and patient is one where the controlling expert relates to the patient as an object to be carefully observed, evaluated and expediently dealt with by effecting a 'cure'. This arrangement is utilitarian in that the role of physician is that of provider of good consequences, and his/her actions are good to the degree they bring about happiness, *ie* in this case, relieve pain and suffering. This suggests the picture of the powerful physician, who, through his or her skill and expertise, acts upon the more passive patient who cooperates obediently and thereby is restored to health.

On the face of it, the clinical model, which characterises the teleological/utilitarian approach, appears to be one with which would be difficult to find fault. How could we argue with a model that tells the physician to act towards patients in such a way as to alleviate their misery? This clinical model is the oldest conceptual model of the doctor-patient relationship and it underlies much of medical practice. The reason for this is that in the

past it has been assumed that the reason patients come to the doctor is because of some disorder which gives pain or discomfort and which, as such, falls well within the framework of the clinical model. There is a tendency to assume that biomedical science and technological advances can contribute to the management of most problems patients bring to physicians. However, studies in the more recent past, most notably, the National Ambulatory Medical Care Survey (NAMCS) (1), suggest that this is not the case. The following is an interpretation, derived from these studies, of what has been called the 'content' of family practice (Carmichael L P. What is family practice? Paper submitted for publication). This interpretation is visually depicted in the diagram (Fig. 1).

In roughly half of the ambulatory encounters with his or her general practitioner, the patient has an illness in which there is objective evidence of physical pathology. In 15 of the 50 this is a problem that may result in significant impairment or death if left untreated. The adequate management of the disease in five of these patients (one-third of the progressive disorders) requires the services of one or more specialists. In 10 of the 15 (two-thirds of the progressive group) successful management is within the capability of the family physician. The approach to these progressive problems that results in a cure or control (either quickly or at some hoped for time in the future) by a pill or a procedure has already been described as the clinical model and is seen as appropriate in these instances.

The remaining 35 of 50 encounters involving physical disease are for conditions that are self-limiting, that is, disorders to which the species or individual has successfully adapted. The role of the physician in self-limiting problems is to provide relief of symptoms, and in some cases to hasten recovery, but these ministrations, while they may be palliative, do not alter the outcome, *ie*, resolution without significant impairment. Of the remaining 50 encounters in which there is no objective evidence of a biological base for the disturbance, 35 are manifestations of a disorder involving the emotions or feelings. These are referred to as psychosocial problems. Prevention orientated services such as check-ups, prenatal care, immunisation, etc. account for another 10 of the 50. The remaining five per cent of patients seek medical services for something that the physician is socially or politically

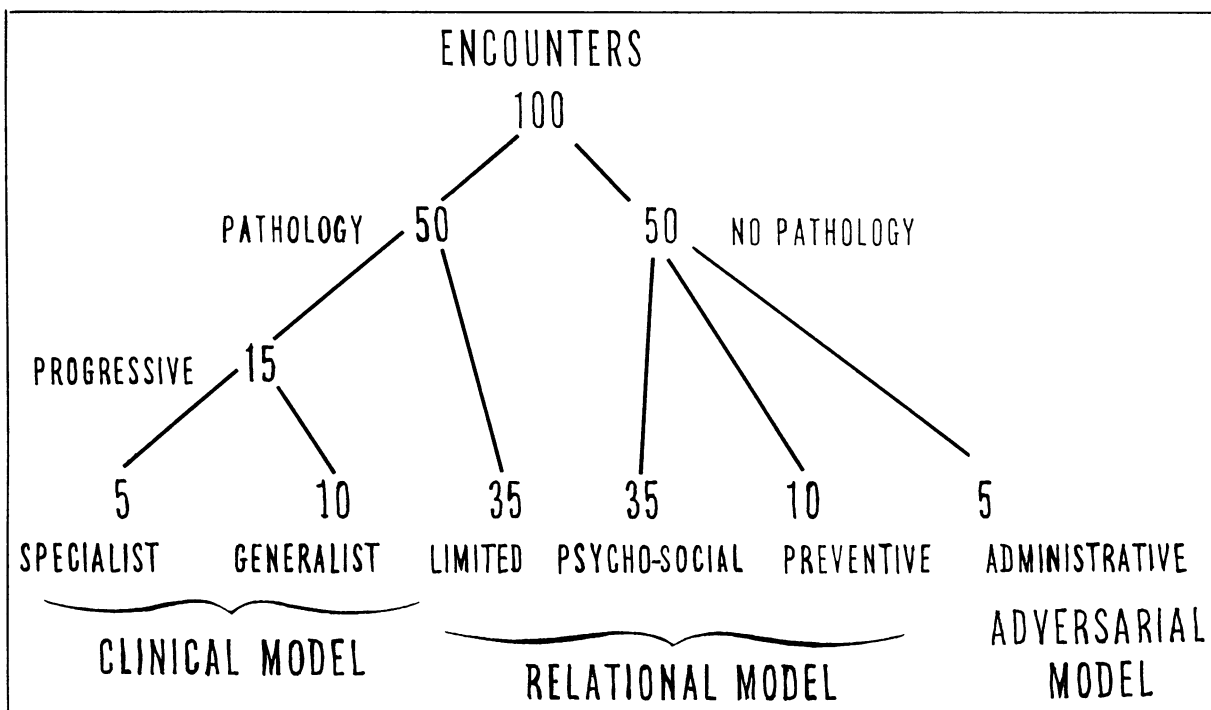


Fig 1. Content of general medical practice

(Chart devised by L P Carmichael, MD from data included in NAMC Survey, 1975)

sanctioned to provide. An example is certification of disability. For this five per cent of encounters the physician is placed in what may be characterised as an adversarial relation to the patient.

An important indication of the NAMC Survey is however, that in 80 per cent of the encounters (35 per cent self-limited diseases, 35 per cent psychosocial problems and 10 per cent preventive services) the clinical model is not appropriate; that is, 80 per cent of the patients who consult their family physician, do not fall appropriately under the rubric of the clinical model. The question now becomes, 'Does it then follow that such a patient is not deserving of or, to put it more strongly, has no right to the services of a family physician; or conversely, that the physician has no duties or responsibilities to such a patient for whom the clinical management model is inappropriate?'

There is the tendency in medical schools to nourish the view that any discomfort beyond organic aberrations, which fit so comfortably into the clinical model, are outside the sphere of physician concern. Doctors themselves frequently express the view that their professional duty lies in applying the 'healing arts' of medicine as they were taught in medical school. The results of the NAMC Survey suggest that a redefinition of 'healing arts' may be in order. As the accompanying diagram shows, an important distinction exists between the services that a physician can render to a patient by the application of his/her expertise as a biological engineer and other services that go

beyond that of body mechanics. The importance of the data illustrated in Figure 1 is that they clearly reveal that the clinical model in the vast majority of patient encounters in a general medical practice is not an appropriate basis for the doctor-patient relationship and that a more useful model needs to be developed.

Toward this end the term 'relational model' has been coined to refer to the 80 per cent of the encounters in which successful resolution of problems cannot be definitely attributed to the services provided by the physician. Self-limiting disorders are by definition ultimately resolved. While success is claimed by those who care for patients with psychosocial disorders, the infinite number of variables in the life of a client and therapist render a causal relationship impossible to determine. In prevention there is a statistical basis for championing the use of, for example, a vaccine or diet change, but one cannot positively attribute avoidance of a particular problem to these measures or guarantee a desired result in a specific patient. Accordingly, in this type of service the focus shifts from the actual consequences of the therapeutic action to the *quality of the process*.

In emphasising the quality of the process, the relational model is compatible with the deontological position of Immanuel Kant. In a deontology certain features of acts themselves are seen to be ultimately right-making over and above any results that may ensue; as such, an act may be right even if it fails to produce beneficial consequences.

In Kant's deontology, the rightness of an interaction depends upon treating a person as an end in himself/herself rather than as a means to some consequence. Kant comes to this position by maintaining, as did the Greeks, that humans are rational animals and that their rationality entitles them to the right to be treated as beings of absolute worth and dignity in themselves. This is because, according to Kant, each rational being recognises that she/he has a worth and dignity apart from any end to which she/he might serve as a means. Such a rational being, from Kant's point of view, would always treat other rational beings the same way she/he would want to be treated, since to do otherwise would be inconsistent and inconsistency is abhorrent to rational beings. This is what prompts Kant to stress in his *Foundations of the Metaphysics of Morals* that in dealing with human beings, a person should act to treat other persons as ends in themselves and not as means only (2). This is to say that in dealing with another rational being one ought to take into consideration the other's absolute worth as an individual self. If, contrary to this, we treat him/her as a means merely, even as a means to good consequences, then we use him/her only for some purpose, thus violating his/her right to be treated as an end.

Characteristics of relational model

The 'relational model' is Kantian in spirit in that it focuses on the quality of the process of physician-patient interaction rather than the successful management of the case. This being so, what would be the characteristics of such a relationship, as opposed to the characteristics of a management-clinical model relationship? Instead of the physician's role being that of expert dispensing knowledge and technical skill for the patient who passively receives, the relationship now becomes a participatory one for both parties. Each takes an active role in the process since the hierarchical relationship of the management model is no longer applicable. Thus, what is of concern here is whether the patient is treated as a person, not in the weak sense of that term, where the physician's concern is primarily a physical one and where, in the course of treatment, the physician is careful to treat the patient politely and not insult him/her, but in the strong Kantian sense of recognising autonomy and all that this entails. To treat someone as a person in this sense requires the physician to recognise the right of the individual to be treated, by virtue of his/her rationality, as a being of absolute worth, apart from any beneficial consequences that may result, such as those aiding in the eventual successful outcome of the case. In a medical setting this would mean, for example, not just recognising the patient's right to make choices concerning his/her treatment, but more importantly it involves the physician's

duty to provide information in such a manner so that the patient can choose knowledgeably and wisely based on the patient's own value system.

It is interesting to speculate on the possible beneficial consequences for the physician in treating patients as persons in the Kantian sense; although it is clear that Kant would not tolerate such benefits as a reason for doing so. For example, the doctor may well become less vulnerable to the increased tendency toward malpractice suits that has developed as doctors have moved more and more toward a clinical model approach to patient relationships. It is interesting that as technical skills have increased and medicine has become more precise, so too, has patient distrust and dissatisfaction as manifest in litigation. As the physician regards the patient as 'other', to be viewed as a means to a defined goal, if that goal is not forthcoming, the physician is seen to be held accountable.

The 'relational model', as has been pointed out, stresses the quality of the process in the interaction between physician and patient. A question that needs to be raised is, 'whence does this quality of process gain its validity?' What reasons can be offered for initiating the process in the first place? There are several positions that fall within the parameters of the 'relational model'. From a strictly Kantian view, the justification for initiating the process need go no farther than the fact that the patient requests it. The motivation or intentions of the physician, for Kant, should be found in the physician's duty to treat the patient as a being of absolute worth, and the patient's right to receive that treatment divorced from any possible goal that might be envisioned. Thus, the process is judged to be of good quality if these conditions are satisfied.

The adoption of a strict Kantian position in which the process relationship which characterises the 'relational model' needs to be initiated on no more justification than the patient's desire would seem to impose on the medical profession a standard of activity not required of any other profession. A more moderate and acceptable position would be that rather than justifying physician duties merely on the basis of a patient's desires or wants, a patient's *need* would be a fairer use of medical resources. 'Need' in this instance would not be restricted to a breakdown in body mechanics but would deal with disturbed functioning in such areas as inter- as well as intra-personal relations, vocational activities or other stress related conditions. Thus, while the 'relational model' can be interpreted purely in Kantian terms, it is not necessary to do so, and it is the scope of the 'relational model' that makes it particularly attractive. A teleologist with a wider perspective than the 'clinical model' affords can feel comfortable with the 'relational model'. Instead of equating right action with 'cure' or proper management of disorder, this

teleologist can be more multidimensional in the 'goods' which the physician can offer the patient. In this interpretation of the 'relational model' the importance of the quality of the process is acknowledged and 'outcome' is defined as comfort or care rather than cure. The breadth of the 'relational model' allows it to be constructed in two ways to satisfy either a deontologist or a broad-based teleologist, in that:

- a) it can be construed as a view that is not concerned with consequences at all, in which case the motivation of the physician stems solely from a sense of obligation to treat persons as ends only, or
- b) it can be seen as a theory that recognises the physician's obligations to attempt to bring about beneficial consequences for his/her patients based on their needs as persons outside his/her technical skill (as opposed to other skills he possesses) as a successful clinical manager of their case.

The 'relational model' is compatible with both a process deontology, and a wider teleology, while the clinical model is compatible only with the narrowest of teleologies.

It is obvious from the NAMC Survey that the family practitioner is faced with two basic types of encounters. He/she has two options in meeting the needs of the patient. There are those few patients suffering from a remediable progressive disorder which will result in death or disability. In such cases the primary concern of the physician is with the outcome of the disease process. The needs of the patient warrant that the purpose and goal of the relationship be the successful management of the disorder. However, when the patient encounter is one in which there is pathology of the self-limiting type, or in those cases where there is no pathology, the imposition of the 'clinical model' can no longer be defended, and is possibly counter-productive, perhaps even destructive. That is, beyond the inappropriateness of the clinical model to meet all situations the responsible family physician must also guard against the temptation of looking for outcome and trying to utilise the clinical model inappropriately, in order to avoid the very real possibility of danger to the patient that might be incurred. In the search for a medical goal which may be pursued, the physician may involve the patient in useless and unnecessary tests, drug

dosages and procedures or treatments that may in fact be damaging.

The NAMC Survey data reveal that, in addition to technical medical skills needed by the family physician, in family practice the physician is most often called upon to relate to a patient whose complaints appropriately lie outside the boundaries of the 'clinical model' and pertain instead to the affective state. In most instances involving the family physician, there is little likelihood that the patient's problems will result in either death or disability. The medical problems are usually self-limiting in that the organism has within itself the ability to resolve the problem, or there is no pathology as measured by objective evidence. Still, the patient seeks the family physician because she/he is uneasy, uncomfortable, 'dis-eased' rather than diseased. According to the 'relational model' she/he has a need to be *cared* for and the physician meets this need by extending his/her services. The nature of those services, however, will have shifted focus to that of *process* rather than product, *care* rather than cure, and appropriately away from a narrow teleological relationship as physician and patient relate to each other as persons, both of whom possess equal inherent value.

The compelling reason for adopting the 'relational model' as the paradigm for the patient-doctor relationship is precisely that it gives due attention and weight to the absolute value of both physician and patient as persons who have mutual obligations of respect for each other, neither using the other as a means merely.

Acknowledgement

The author wishes to acknowledge her indebtedness to Dr Lynn Carmichael, Chairman of the Department of Family Medicine University of Miami School of Medicine, and Thomas Crowder, of the same department, for their assistance in developing the ideas expressed in this paper.

References

- (1) De Lozier. *National Ambulatory Medical Care Survey 1973 Summary*. DHEW Publication No 1772. Series 13, Number 76. Washington, DC National Center for Health Statistics, 1975.
- (2) Kant I. *Fundamental Principles of the Metaphysics of Morals*, trans. T K Abbott. New York, NY Longmans, Green & Co, 1909: Sections 1 and 2.